

REPORT ON LEAD POISONING SYMPOSIUM

HELD BY THE

HOUSE COMMITTEE ON STATE GOVERNMENT

AT THE UNIVERSITY OF PITTSBURGH

WITH REFERENCE TO

HOUSE BILL NO. 81, PRINTER'S NO. 94

("LEAD PAINT POISONING BILL")

JUNE 6, 1974

COMMITTEE ON STATE GOVERNMENT

HOUSE OF REPRESENTATIVES

HONORABLE GUY A. KISTLER, CHAIRMAN

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Report on Lead Poisoning Symposium
Held in Scaife Hall, Auditorium
University of Pittsburgh By The
House State Government Committee

The House Committee on State Government held a hearing on House Bill 81, Printer's No. 94, the Lead Paint Poisoning Bill, in conjunction with a symposium entitled "Lead Poisoning--A Public Health Problem," sponsored by the Allegheny County Health Department, Children's Hospital of Pittsburgh, the Pittsburgh Poison Center and the Division of Continuing Education of the University of Pittsburgh School of Medicine.

A transcript of the testimony presented by specialists in related fields, taken by a certified public stenographer, will be sent to Chairman Guy A. Kistler by July 1, 1974.

Participation by State Government Committee staff occurred during two fifteen minute question and answer periods.

Doctor Richard W. Moriarty, Assistant Professor of Pediatrics at the University School of Medicine and Director of the Pittsburgh Poison Center, key-noted the scope of the symposium as being far wider than a poisoning problem attributed directly to children ingesting lead-based paint chips.

He pointed to the fact that there were no nationwide or statewide statistics available to help determine the extent of the lead poisoning problem, how large a segment of our population (both adult and child) are affected, what percentage of those affected is due to ingesting lead paint particles, breathing in lead dust and tetra ethyl fumes or absorbing leachable lead into the system through direct contact.

Doctor Moriarty stressed the apparent existence of other variables in the lead poisoning problem when he compared the findings of Federally financed pilot screening programs to determine the extent of lead-based paint poisoning among children under six years of age in inner-city Pittsburgh, with findings in similar neighborhoods in Philadelphia. Where there was a high incidence of reported lead poisoning with high blood levels directly traceable to lead based paint chips being gnawed from woodwork and eaten or licked from fallen plaster and floors with brain damage and death resulting in the Philadelphia children; this was not the case in Pittsburgh. In the similar inner-city neighborhoods in Pittsburgh with housing dating before 1940 (the cut-off period for most housing painted with hazardous lead paint) the children screened in the pilot program had substantially lower lead levels in their blood; there were not so many cases treated; and there were no lead paint poisoning deaths in Allegheny County.

This lead Doctor Moriarty to believe that there might be other factors or a combination of factors present to account for the difference.

Mr. Dudley Anderson, Chief of Lead Poisoning Control Programs for Community Action in the Federal Department of Health, Education and Welfare, traced the history of man's use of lead substances from ancient times to the present. Although the ancients used lead as water conduits, as a base for medicine, cosmetics, barrels to collect rain water and cooking and eating utensils, they failed, for the most part, to tie the epidemic outbreaks of colic, paralysis and excruciating abdominal pain recounted by some Roman physicians and historians, to the prevalent use of soluble lead. With renewed interest in pewter mugs and their use for drinking beverages and the presence of leachable lead in glazed pottery, toys and other products, these ancient symptoms are again a threat to life.

In the early 1950's physicians reported a high incidence of lead poisoning among inner-city youngsters. Subsequent research traced it to lead-based paint ingested by children. As public awareness of the hazard increased, popularity of lead as a primary paint ingredient decreased. So in 1971, Congress acted to restrict the use of lead in paint. However, that did little to resolve the fact that lead-based paint was already applied to interiors and exteriors of most United States housing built before 1940. To show the magnitude of the problem the 1967 census listed 30.6 million occupied housing units built prior to 1940, with 1.3 million in New York City alone. In Philadelphia, in 1970, there were an estimated 400,000 of the city's 650,000 housing units containing lead-based paint in quantity.

Testimony showed that the task of removing the lead-based paint was hazardous, too. Sanding it produced lead dust; heat softening produced lead vapors and paint removers were not only expensive but flammable and toxic. Electrically operated heat guns were recommended as the best method for removal. Also, wall board, plywood, vinyl and burlap fabric were recommended to cover up peeling and flaking paint.

Federal law, addressing itself primarily to hazardous amounts of lead in paint as a source of the problem, states that prior to December 31, 1974, the new definition of lead-based paint would be .5 per cent; and after that date the definition would be .06 per cent lead by weight, except if Consumer Product Safety Commission research determines another level of lead, not exceeding a maximum .5 per cent, to be safe. The tremendous problem in this area concerns distinguishing 'leachable lead' from 'lead present' in the product.'

Medical testimony showed the difficulty in determining the extent of lead poisoning in the system and setting acceptable levels by which to gauge exposure. Among many methods, blood tests appear to be the most effective; but using macro tests (taking 10 to 15 cc's of blood from small children) gave way to micro tests, which are now used in pilot test screenings.

According to the Surgeon General, a child's blood level showing a lead content of 40 micrograms would constitute normal exposure; lead content of 40 to 59 micrograms should be watched; 60 to 79 micrograms would necessitate therapy; and 80 micrograms and above would call for hospitalization.

Experts consider that continuous exposure to leachable lead leads to a dangerous accumulation in the body. Lead accumulates in the long bones of the body as opposed to the flat bones, and takes as long as ten years to leave the bones.

With continued exposure, not only to lead-based paint but an accumulation of leachable lead from water, food and air, the prospect of large segments of our population being slowly poisoned loomed as a definite and frightening possibility to the symposium participants.

Many voiced the opinion that if legislation was needed to address itself to the problem of lead poisoning and funds were to be appropriated to alleviate that problem, the first step on a Federal and State basis, would be to properly identify the extent of the problem. Funds should be expended to gather the necessary data upon which to base an effective program of detection, treatment and elimination of the poisoning.

They felt that the lead-paint poisoning problem was like the tip of an iceberg--dangerous and frightening to behold; but what lurked below the surface could be of vast dimensions and even more hazardous.

Dorothy K. Tully, Legislative Analyst
House Committee on State Government